



# Green Mountain Surgery Center

593 Hercules Drive  
Colchester, Vermont 05446-5993  
802-488-5350

## Free or Discounted Care Application:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Total Monthly Household Income: \_\_\_\_\_ # of persons in your household: \_\_\_\_\_

Sources of Income: \_\_\_\_\_

\_\_\_\_\_

The above information is true and accurate. I understand that this declaration is used to help verify that I meet the requirements to receive free or discounted services. I understand that a false or misleading declaration by me may result in discount adjustments for which I would not otherwise have qualified and may subject me to civil and criminal penalties.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

(Please attach evidence of Household Income, which may include: pay stubs, written verification of wages from employer, W-2 withholding form, social security or disability benefit statements, unemployment or pension/annuity benefits, or supplemental security income statements.)